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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAEL SOPHIA STIMMING, L.M.** 5607 Sobrante Avenue El Sobrante, CA 94803-1534 Licensed Midwife Certificate No. LM 332, Respondent.	Case No. 800-2022-087495 **A C C U S A T I O N**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On March 20, 2012, the Division of Licensing issued Licensed Midwife Certificate Number LM 332 to Lael Sophia Stimming, L.M. (Respondent). The Licensed Midwife Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2023, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2052 of the Code provides:

"(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter or without being authorized to perform the act pursuant to a certificate obtained in accordance with some other provision of law is guilty of a public offense, punishable by a fine not exceeding ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment.

(b) Any person who conspires with or aids or abets another to commit any act described in subdivision (a) is guilty of a public offense, subject to the punishment described in that subdivision.

(c) The remedy provided in this section shall not preclude any other remedy provided by law."

5. Section 2225.5 of the Code states, in relevant parts:

" (b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals."

"...."

"(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license."

6. Section 2519 of the Code states:

"The board may suspend, revoke, or place on probation the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that this use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any

examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

(1) Consult with a physician and surgeon.

(2) Refer a client to a physician and surgeon.

(3) Transfer a client to a hospital."

7. The incidents alleged herein occurred in Contra Costa County and Sacramento County, California.

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

9. Respondent Lael Sophia Stimming, L.M., is subject to disciplinary action under section 2519(a)(1) of the Code, in that her care and treatment of Patient 1 and Patient 2[1] included unprofessional conduct constituting gross negligence or incompetence. The circumstances are as follows:

[1] To preserve patient confidentiality, the maternal patient is identified herein as Patient 1 and her infant child as Patient 2. The patients' full names will be provided to Respondent upon request.

10. On November 27, 2019, three-day old Patient 2 was seen in the emergency room at Sutter Medical Center, Sacramento; his parents informed the attending physician that Patient 2 was lethargic and was not yet breast-feeding. Patient 2's parents—his father and Patient 1, his mother--were accompanied at the hospital by Claudette Coughenour, a formerly-licensed midwife who provided midwife care at Patient 2's homebirth. Ms. Coughenour was ostensibly providing care in the capacity of a midwifery student, being supervised by Respondent, who was also present at Patient 2's homebirth.

11. The hospital's attending pediatric intensivist physician examined Patient 2 and immediately admitted him to the pediatric intensive care unit. Numerous physicians provided round-the-clock care to Patient 2, but despite extensive clinical interventions, Patient 2 died on December 1, 2019. The postmortem examination established that Patient 2 had died of multi-organ failure as a consequence of an interrupted aortic arch, a congenital condition that caused insufficient blood flow after birth. That congenital condition would very likely have been identified by a timely pre-natal ultrasound screening, and would have certainly have manifested itself by clear symptoms readily identified by a competent post-natal examination of newborn Patient 2.

12. In her November 16, 2022, interview with Board investigators, Respondent acknowledged that she was aware that Claudette Coughenour had previously been licensed as a midwife in California, and that Ms. Coughenour had surrendered her license some years ago. Respondent stated that she was unaware of the circumstances attending Ms. Coughenour's license surrender and had never asked Ms. Coughenour about those circumstances. Respondent stated to Board investigators that she, as the sole licensed midwife, was responsible for supervising Ms. Coughenour in the midwifery care the two provided to a number of patients, including Patient 1 and Patient 2, and that she, not Ms. Coughenour, made and maintained the medical records of the midwifery care provided.

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13. Respondent and Ms. Coughenour began providing prenatal midwifery care to Patient 1 approximately midway through the course of Patient 1's 2019 pregnancy.[2] In her interview with Board investigators, Respondent stated that she had specific memory of the prenatal and labor midwifery care provided to Patient 1, that she had obtained informed consent from Patient 1 for the anticipated midwifery prenatal care and homebirth, and that she believed Patient 1 obtained all her prenatal care from Respondent and Ms. Coughenour. Respondent told Board investigators that she had obtained results of ordered bloodwork for Patient 1 and had referred her at 20 weeks gestation for an ultrasound examination and that she was "90 percent sure" that Patient 1 had undergone an ultrasound examination and that there was "nothing detected on the 20-week ultrasound, from my recollection." When questioned further on the specifics of her personal knowledge of the report of the ultrasound examination of Patient 1, Respondent acknowledged that she could not be sure she had seen the actual report of the results of the 20-week obstetric ultrasound examination, that perhaps she had merely been told by Patient 1 that the results showed "everything was good." According to Respondent, the duration of Patient 1's pregnancy was uneventful.

14. Patient 1 went into labor on November 24, 2019, and both Respondent and Ms. Coughenour attended the birth at Patient 1's Sacramento home. Respondent told Board investigators that the labor was rapid, describing it as "such a great birth," and said that she then performed the full newborn examination, including assessing Patient 2's femoral pulse. According to Respondent, Patient 2 cried soon after birth and began breastfeeding before Respondent left the home.

15. According to Respondent in her statements at her interview with Board investigators, she did not see Patient 1 and Patient 2 on the first day following the birth, but received a telephone call from Ms. Coughenour either that first post-natal day or the following day, but "...definitely within 48 hours" of Patient 2's birth. Ms. Coughenour was reportedly at Patient 1's

[2] The specific facts of the care Respondent provided to Patient 1 and Patient 2 cannot be established by reference to Respondent's documented record of that care because—as detailed in paragraphs 23 and 24 herein—Respondent has failed to comply with a court order to provide those records to the Medical Board.

home, and related to Respondent that infant Patient 2 was not readily breastfeeding and was "blue around the mouth." Respondent maintains that she told Ms. Coughenour and Patient 1, on a speakerphone conversation, that Patient 2 should be seen at a hospital. Respondent did not see Patient 1 at any time after the initial post birth examination. It was on day three after Patient 2's birth that Patient 1, accompanied by Ms. Coughenour, took Patient 2 to be seen at Sutter Medical Center, Sacramento.

16. Respondent has subjected her license to disciplinary action for unprofessional conduct in that her failure to obtain a clinically adequate family medical history for Patient 2 precluded her from conducting a more thorough clinical assessment to rule out the congenital anomaly that affected Patient 2, a departure from the standard of care constituting gross negligence or incompetence in violation of section 2519(a)(1) of the Code.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

17. Paragraphs 10 through 15 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct under section 2519(a)(1) of the Code, in that her failure to either personally review the results of Patient 1's 20-week obstetric ultrasound examination or to appreciate the clinical significance of the probable clinical indication of Patient 1's interrupted aortic arch constitutes gross negligence or incompetence.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

18. Paragraphs 10 through 15 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct under section 2519(a)(1) of the Code, in that her failure to perform an clinically adequate newborn examination of Patient 2--including an adequate assessment of the infant's femoral pulse--precluded an immediate transfer of care to a pediatric critical care setting to timely address Patient 2's serious congenital condition and constituted gross negligence or incompetence.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

19. Paragraphs 10 through 15 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct under section 2519(a)(1) of the Code, in that her failure to see and examine Patient 2 on the days immediately following his birth constituted gross negligence or incompetence.

FIFTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

20. Paragraphs 10 through 15 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct under of section 2519(a)(1) of the Code, in that her failure to effect an immediate transfer of Patient 2 to hospital care upon being informed of his failure to breastfeed and perioral cyanosis, relying instead on an unlicensed midwife student to effect that transfer of Patient 2 in timely manner and to communicate relevant clinical information to the receiving physician, constituted gross negligence or incompetence.

SIXTH CAUSE FOR DISCIPLINE

(Aiding/Abetting Unlicensed Practice)

21. Paragraphs 10 through 15 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct under sections 2519(e) and 2511 of the Code, in that permitting Claudette Coughenour, an unlicensed midwifery student, to be solely responsible for effecting the transfer of care of Patient 2 to a clinical setting and competently and completely communicating the relevant clinical information of Patient 2's prenatal and postnatal care and condition to the receiving physician, aided and abetted the unlicensed practice of midwifery.

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SEVENTH CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

22. Respondent Lael Sophia Stimming, L.M., has subjected her license to disciplinary action for unprofessional conduct, in that her failure to maintain adequate and accurate medical records of the midwifery care rendered Patient 1 and Patient 2 is a departure from the standard of care constituting unprofessional conduct in violation of section 2519 of the Code.

23. In the course of the Board's investigation of the midwifery care rendered by Respondent to Patient 1 and Patient 2, Respondent was personally served an investigative subpoena duces tecum for her medical records regarding Patient 1 and Patient 2 on or about May 17, 2022. Citing Patient 1's privacy concerns as the basis for an objection to the production of her medical records, Respondent refused to produce the requested records.

24. Upon petition by the Board, the Superior Court of Contra Costa County issued an Order to Show Cause to Respondent, affording her the opportunity to be heard on the failure to produce the subpoenaed records. On October 24, 2022, after a hearing at which counsel for Respondent presented argument, the Superior Court issued an order directing Respondent to comply with the regularly-issued subpoena by or before November 3, 2022. Respondent has failed to produce any of the medical records she told Board investigators she had made documenting the midwifery care she and Ms. Coughenour had provided to Patient 1 and Patient 2, stating that she gave the original treatment records to Patient 1 without retaining a copy and that Patient 1 has not returned the records to Respondent.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Comply With Court Order Re Subpoena—Civil Penalty)

25. Paragraphs 23 and 24 above are incorporated by reference as if set out in full. Respondent Lael Sophia Stimming, L.M. is subject to disciplinary action for unprofessional conduct and to imposition of a civil penalty under section 2225.5(b) of the Code for her failure to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the Board.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Licensed Midwife Number LM 332, issued to Lael Sophia Stimming, L.M.;

2. Ordering Lael Sophia Stimming, L.M., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Lael Sophia Stimming, L.M., to pay the Board a civil penalty of $10,000.00 pursuant to Code section 2225.5 (b)(1); and

5. Taking such other and further action as deemed necessary and proper.

DATED: MAR 0 9 2023

REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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